

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-020754

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5542

FILED JUN 7 1962

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN St. Louis

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION Good Samaritan HomeInside Limits  
Yes ☐ No ☐

a. STATE

Mo. b. COUNTY

admission)

c. CITY  
OR TOWN

St; Louis

Inside Limits  
Yes ☐ No ☐d. STREET  
ADDRESS

(If outside, give location)

5200S Broadway

Reside on Farm  
Yes ☐ No ☐3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

Mary

C

Miller

4. DATE  
OF DEATH

Month

Day

Year

5

31

62

5. SEX  
F6. COLOR OR RACE  
W7. Married ☐ Never Married ☐  
Widowed ☒ Divorced ☐8. DATE OF BIRTH  
3/4/18739. AGE (last birthday)  
89IF UNDER 1 YEAR IF UNDER 24 HR  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)  
HW

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)  
Ill.12. CITIZEN OF WHAT COUNTRY  
USA

13a. FATHER'S NAME

Claus Luedemann

13b. MOTHER'S MAIDEN NAME

Margaret Schwarz

14. NAME OF HUSBAND OR WIFE

Henry

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT  
AAAddress Columbus Ohio  
Christ Miller 4681 Scenic Dr.18. CAUSE OF DEATH (Enter only one cause per line  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Apoplexy -

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

DUE TO (b)

Hypertension

DUE TO (c)

Sen. arteriosclerosis

INTERVAL BETWEEN  
ONSET AND DEATH  
9 wks.PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal  
disease condition given in PART I (a)

334X

PART III. If deceased was female was  
there a pregnancy in last 90 days.☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒20a. ACCIDENT SUICIDE HOMICIDE  
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF  
INJURYHour  
a.m.  
p.m.20d. INJURY OCCURRED  
WHILE AT WORK ☐  
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,  
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 3/24/62 to 5/31/62 and last saw her alive on 5/29/62  
Death occurred at 7:15 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Wt. Henry mrs

22b. ADDRESS

5503 Chippewa

22c. DATE SIGNED

6/1/62

23a. BURIAL, CREMATION,  
REMOVAL (Specify)  
burial23b. DATE  
6/2/6223c. NAME OF CEMETERY OR CREMATORY  
New St. Marcus23d. LOCATION (City, town, or county)  
St. Louis, Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Schumacher 3013 Meramec

25. DATE RECD. BY LOCAL REG.

JUN 2 1962

26. REGISTRAR'S SIGNATURE

Joan Smith, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

ITEM NO.

VS 300  
Rev. 4/59

1

2 215

3

4 1

5 2

6

7 1

8 2

9

10

11

12 60

13

86

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.